LEICESTER CITY, LEICESTERSHIRE COUNTY AND RUTLAND

Orthodontic Pathway Referral Form

Practice/Specialist to which the referral is being made:

Patient Details

Surname ……

Forename ……

Title ……

Date of Birth ……

Address ……

Postcode ……

Telephone ……

Date ……

Is another family member being treated at this practice YES/NO

I would be grateful if you could arrange an appointment for the above patient with a view to NHS Orthodontic treatment.
I have followed the guidelines and in my capacity believe this referral to be appropriate. I confirm I have offered the patient choice of all the providers in the LLR area and they have selected your practice.

Your Sincerely,

…… Referring Practitioner

Referring Practitioner contact details or stamp……..

……..

……..

Reason for referral including relevant medical and dental history and any teeth with a poor prognosis

Enclosures (Please detail how many pages are attached)

1 Dental Health Component

Does the patient have;

• impacted teeth (excluding incisors)	No □ Yes □
• canines and other teeth considered impacted if un-erupted and the root apex has completed development	No □ Yes □
• an overjet of greater than or equal to 10mm requiring and or a significant overjet that requires the treatment with both functional (growth modification) and fixed appliances	No □ Yes □
• extensive hypodontia (that is more than one tooth missing per quadrant, not including third molars)	No □ Yes □
• a marked skeletal jaw disproportion that may require the combination of orthodontics and jaw surgery.	No □ Yes □
• Please state patients age at referral (this should be following the BOS recommendations and should be justifiable if called for exception reporting); ……. years and ……. months	

2 Oral Health and Hygiene Component

If the answer to all questions is "No", then the patient does not meet the referral criteria to receive treatment on this pathway.

As the patient's general dentist, I confirm I believe the patient is dentally fit to receive orthodontic treatment (if the referral is accepted).

No □ Yes □

I have also discussed with the patient and guardian the importance of maintaining oral health during orthodontic treatment and the need to attend for regular dental check-ups, as well as attending orthodontic appointments.

No □ Yes □

I have discussed and explained the referral to the patient and guardian and have requested their signature below to confirm orthodontic treatment is wanted.

No □ Yes □

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3 Consent for referral

I, as the **patient** or **legal guardian** (please delete as appropriate), understand the referral being made for orthodontic assessment and understand that this does not automatically mean acceptance to treatment. I have also been offered a choice of provider.

Signed…….. Date……..